Country Activity Plan

Rwanda 1998-2000

May 1999

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Partnerships
for Health
Reform
PHR

Mission

The Partnerships for Health Reform (PHR) Project seeks to improve people's health in low- and middle-income countries by supporting health sector reforms that ensure equitable access to efficient, sustainable, quality health care services. In partnership with local stakeholders, PHR promotes an integrated approach to health reform and builds capacity in the following key areas:

- *better informed and more participatory policy processes in health sector reform;*
- *more equitable and sustainable health financing systems;*
- *improved incentives within health systems to encourage agents to use and deliver efficient and quality health services; and*
- *enhanced organization and management of health care systems and institutions to support specific health sector reforms.*

PHR advances knowledge and methodologies to develop, implement, and monitor health reforms and their impact, and promotes the exchange of information on critical health reform issues.

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United States Agency for International Development

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Acronyms

ARC	American Relief Committee
ASSP	*Acceleration des Soins de Santé Primaire*
CA	Cooperating Agency
CAP	Country Activity Plan
CAMERWA	*Central d'Achat de Médicament du Rwanda*
DED	*Service Allemande de Développement*
DPF	*Direction de Planification et Formation*
DSRO	*Division de Statistique, Recherche et Opération*
DSS	*Division des Soins de Santé Primaire*
EU	European Union
DRG	Diagnosis Related Group
GOR	Government of Rwanda
HCF	Health Care Financing
HERA	Health Research for Action
HMIS	Health Management Information System
HSR	Health Sector Reform
IRC	International Rescue Committee
LT	Long Term
Minisanté	Ministry of Health
MSF/B	*Médecins Sans Frontière / Belgique*
NGO	Non-Governmental Organization
ONAPO	*Office National de la Population*
OPHAR	*Office Pharmaceutique*
PDA	*Plan d'Action*
PHC	Primary Health Care
PHN	Population, Health and Nutrition
PHR	Partnerships for Health Reform Project
PSI	Population Services International
SSP	*Soins de santé primaire*
ST	Short Term
TA	Technical Assistance

UNICEF	United Nations Children's Emergency Fund
UNR	*Université National de Rwanda*
URC	University Research CO., LLC
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization

Executive Summary

This Country Activity Plan (CAP) describes a number of areas where the Partnerships for Health Reform (PHR) Project will provide technical assistance to the Government of Rwanda (GOR). Activities will be carried out in coordination and collaboration with USAID/Rwanda, the Rwandan Ministry of Health (Minisanté), and other country counterparts, between January 1999 and September 2000. To develop this CAP, two PHR staff members traveled to Rwanda in March, 1998 to hold a series of discussions with key representatives from the GOR, Minisanté, USAID/Rwanda, other donor agencies, and non-government organizations (NGOs) working in the health sector in Rwanda. Upon receipt of USAID funding, three PHR staff members traveled to Rwanda in November, 1998 to finalize the activity plan. The activities proposed in this CAP respond directly to the needs identified during these visits.

USAID/Rwanda has requested PHR to assist the Mission in achieving results under the third Intermediate Result (IR3) of its results framework which has been developed to support the Government's ambitious program of health sector reform. Specifically, PHR activities will contribute to IR3 which seeks to enhance the sustainability of primary health care (PHC) services through improved financial accountability and improved health financing, and also contribute to its IR3.2 activities which are aimed at assisting Minisanté to develop and pilot sound health care cost recovery systems that will ensure that Minisanté meets recurrent costs within a rational health care system.

PHR activities in Rwanda are designed to achieve the following three objectives:

1. To develop and test new models of community and health district based cost sharing with equity impacts evaluated

2. To increase human resource capacity in health care financing (HCF) and health sector reform (HSR)

3. To provide analytical support to Minisanté and USAID/Kigali during the transition period as health sector reform unfolds

The CAP covers a 21-month period from January 1999 - September 2000 and has an estimated budget of $1.77 million. The specific activities, objectives, performance indicators, target completion dates, and collaborators for each of these activities are summarized in Table 1 on pages 2- 6.

To implement these activities, PHR will field a Long-Term Resident Advisor who will be supported by considerable short-term technical assistance, management support and oversight from PHR. Rwandan organizations will also be engaged, as available and appropriate, especially to support field research activities.

This CAP also includes monitoring and evaluation plans which list indicators to measure progress in activity implementation and achievement of results and to evaluate the long-term impact of PHR technical assistance on Rwandan health sector policies and programs. Budgets for both years of this CAP are provided in Table 3 on page 29.

Table 1: Proposed PHR Rwanda CAP Activities

Summary of Objectives, Results, Activities, Performance Indicators, and Target Dates and Partners

Activities	Performance Indicators	Timeframe	Partners
OBJECTIVE 1 – Develop and test new models of community and health district based cost sharing with equity impacts evaluated.			
Result 1.1 – Current health service pricing practices assessed in pilot districts.			
1.1.1 Write assessment and interview tools 1.1.2 Implement assessments and interviews 1.1.3 Analyze and disseminate results 1.1.4 Dialogue on results to reach consensus	a. Tools written b. Study conducted c. Results disseminated to decision-makers d. Consensus reached and documented	Jan. -- March 99	Minisanté
Result 1.2 – Reintroduction of CR across Rwanda monitored and evaluated (focusing on selected health districts).			
1.2.1 Monitor implementation of CR via SIS 1.2.2 Conduct field visits to monitor CR	a. Activity and field reports written b. Policy presentation/paper written and presented	Jan.99 -- Sept. 00	Minisanté UNR
Result 1.3 – Rapid feasibility assessment of alternatives to fee-for-service such as mutuelles, pre-payment schemes for health districts or community based insurance programs conducted.			
1.3.1 Review indigenous mutuelles in Rwanda 1.3.2 Analyze household survey data to determine potential household for revenue generation 1.3.3 Present proposals to Minisanté and other key GOR counterparts	a. Proposals presented to Minisanté	February -- July 99	Minisanté

Result 1.4 – Two alternative financing schemes designed and pilot tested.			
1.4.1 Design conceptual framework 1.4.2 Develop scheme management and monitoring tools 1.4.3 Produce evaluation report and health policy presentation	a. Schemes implemented in at least 2 health districts b. Progress reports and final evaluation report written documenting key findings, conclusions and recommendations c. Policy presentation of results	July 99 – Sept. 00	Minisanté Local Governments UNR
Result 1.5 – Exemption mechanisms evaluated and changes recommended in PHR pilot districts.			
1.5.1 Current exemption mechanisms assessed 1.5.2 Prepare policy presentation on exemption policies 1.5.3 Recommend new/changed exemption policy 1.5.4 Develop and institute exemption guidelines in the PHR pilot districts	a. Policy paper on exemption mechanisms produced and presentation made b. New/changed exemption policies recommended c. Exemption guidelines developed and instituted in the PHR pilot districts	May 99 – Sept. 00	Minisanté Local Governments
OBJECTIVE 2 – Increase human resource capacity in health care financing (HCF) and health sector reform (HSR).			
Result 2.1 – One or two local advisors identified for on-the-job training in HCF and HSR.			
2.1.1 Recruit local advisors 2.1.2 Train	a. 1 or 2 advisors hired and trained in HCF and HSR	April – June 99	Minisanté
Result 2.2 – HCF intensive course (2-4 weeks) taught.			
2.2.1 Prepare course 2.2.2 Teach course	a. Course taught, with documentation of number of participants and course curriculum	Jan. – Sept. 00	UNR Medical School and Economics Department Minisanté

Result 2.3 – On-the-job training in health service delivery research during pilot tests provided to DSS staff.			
2.3.1 Train DSS and other Minisanté staff during implementation of pilot tests.	a. DSS and other Minisanté staff trained and included in pilot financing scheme development and implementation	May – Aug. 99	Minisanté
Result 2.4 – Development and implementation of a course on health economics at the UNR.			
2.4.1 Develop draft curriculum 2.4.2 Discuss and finalize curriculum 2.4.3 Procure teaching materials 2.4.4 Evaluate and modify curriculum as needed	a. UNR holds course	Jan. – Sept. 00	UNR Minisanté
OBJECTIVE 3 – Provide analytical support to Minisanté and USAID/Kigali during the transition period as health sector reform unfolds.			
Result 3.1 – Analytical support provided in response to specific requests from Minisanté and USAID/Kigali as mutually agreed and within time and budget constraints related to other objectives.			

1. Introduction and Methodology

PHR seeks to improve people's health by enabling the health sector to provide and ensure equitable access to sustainable, quality health care services. The Project's technical expertise supports and promotes changes in health policies, regulations, financing, and the quality, organization and management of health services from hospitals to clinics, across urban and rural areas, and among the public and private sectors. In carrying out these objectives, PHR works in partnership with national and local governments, communities, non-governmental organizations, and donors.

The PHR assistance requested by USAID/Rwanda provides technical support to the GOR health sector reform process and responds to USAID/Rwanda health sector strategic objectives. Minisanté has identified a series of priority activities and objectives in Minisanté "Plan d'Action" (PDA). Health reforms include a focus on development of human resources, decentralization, and institutional strengthening. A more detailed description of GOR strategies can be found in Section 3.1 on page 7. In turn, the USAID/Rwanda's strategic plan for health follows closely the PDA so that there are clear and direct linkages between what Minisanté wants to achieve and what USAID has formulated as goals. In the course of the PHR assessment, considerable evidence was found to validate the approach outlined by Minisanté and USAID to resolving Rwanda's health problems. Therefore, PHR activity areas adhere closely to Minisanté and USAID objectives, and the PHR framework is based upon the existing strategic plans of the GOR and USAID. Figure 1 on the following page illustrates this strategic framework and illustrates the linkages between SOs, IRs, and PHR activity areas.

USAID is in the process of developing a results framework covering all of its activities in child health, family planning, nutrition, and HIV/AIDS prevention and control, and which corresponds to the goals of the government's agenda. The ultimate objective of PHR assistance is to accomplish Minisanté and USAID objectives as spelled out in the relevant sections of Minisanté PDA and USAID's results framework. The USAID Strategic Objective for health, population, and nutrition activities (SO2) is to "increase the use of health services and change behaviors relative to STI/HIV, maternal, and child health by building service capacity in target areas" as a means of achieving the goal of sustainable improvements in the health status of Rwandans. All PHR activities fall under Intermediate Result IR3 and the Activity Area IR3.2 (below) which are designed to contribute to the achievement of this strategic objective:

IR3 Enhanced sustainability of primary health care (PHC) services through improved financial accountability and improved health financing.

IR3.2 Activities aimed at assisting Minisanté to develop and pilot sound health care cost recovery systems that will ensure that Minisanté meets recurrent costs within the national health care system.

From the many possible areas of intervention, PHR has chosen three main areas where actions leading to results are vital to efforts to assist the health reform process in Rwanda. The objectives of PHR activities are:

1. To develop and test new models of community and health district based cost sharing with equity impacts evaluated

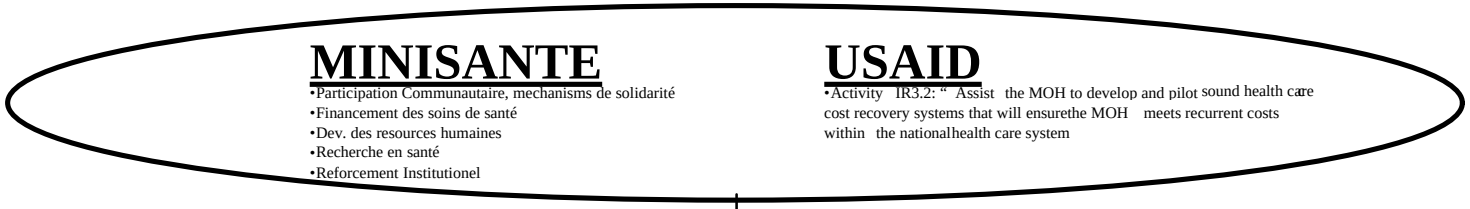
2. To increase human resource capacity in health care financing (HCF) and health sector reform (HSR)

3. To provide analytical support to Minisanté and USAID/Kigali during the transition period as health sector reform unfolds

In each of these areas, PHR proposes concrete results and a series of activities designed to lead to the accomplishment of the stated objectives.

This CAP proposes activities to be carried out in these areas by PHR, in collaboration with local counterparts and other CAs and donors, as appropriate. This CAP was developed during PHR visits to Rwanda in March and November 1998 during which the teams held a series of discussions with the government, Minisanté officials, USAID, representatives of the private sector, and donor agencies, including the World Bank and the European Union. PHR also held discussions with other CAs working in Rwanda including the URC Quality Assurance Project. From these discussions, needs were identified, as well as specific activities to meet these needs. This CAP presents detailed activities to be conducted during the twenty-one months of PHR assistance from January 1999 to September 2000. Activities for Year 2 will be further defined once first-year activities are underway.

Strategic Framework for PHR Assistance in Rwanda



New models of community and health district based cost sharing developed and tested	Increase Rwandan human resources in health care financing and health sector reform	Respond to need for analytical support during transition period as health sector reform unfolds
Conduct rapid feasibility assessment of alternatives to fee for service such as mutuelles, pre-payment schemes run by health districts or community based insurance programs. Design and pilot test 1-2 alternative financing schemes. Pilot test alternative models of organizing and delivering health services (e.g., performance based contracts for health centersor districts, contracting out, health district Autonomy, other alternative provider payment mechanisms)	Hire 2 local resident advisorsfor on the job training in HCF and HSR (office in DSS). In conjunction with UNR Medical School and Econ. Dept., teach yearly intensive course (2-4wks) in HCF On the job training for staff of DSS in health service delivery research during pilot tests Support for development and inclusion of course on health economics at UNR	CAMERWA: how to optimally set prices for drugs sold to districts to balance sustainability and health objectives Heath service provider Incentives: impact of salary supplements on location and labor supply decisions, likely impact of withdrawalof NGOs

2. Background

Rwanda has suffered severe shocks in the 1990s, most notably the genocide and war of 1994 that resulted in the death and displacement of large numbers of people, the destabilization of economic activity for a number of years, and the destruction of much of the health infrastructure. Demographic shifts affect as much as one-half of the population. In addition to resettlement and rehabilitation needs, the country has suffered a huge loss of human resources through flight, participation in the genocide, and/or death. Nonetheless, the country is gradually phasing over from a crisis assistance mode to a development posture.

Table 2: Selected Health-Related Statistics for Rwanda

General:	
Population Size (1998 estimate)	7.6 million
Population Growth Rate (a)	1.7 1980-96 3.5 1996-2010
GNP per capita (1996) (a)	$ 190
Health Status Indicators:	
Infant Mortality Rate per 1,000 live births (1996) (a)	129
Child (< five) Mortality Rate per 1,000 live births (1996) (b)	170
Life expectancy at birth (years) (1996) (a)	41
Total Fertility Rate (1996) (b)	6.2
Health Services Utilization Data:	
Percentage of births attended by a trained health professional (1990-96) (b)	26
Percentage of 1-year olds fully immunized (b):	TB 93 DPT 98 Polio 98 Measles 76
Health Resources:	
Percent of GDP allocated to health (1990-95) (a)	1.9
Physicians per 1,000 people (1994) (a)	<0.1
Hospital beds per 1,000 population (1994) (a)	1.7

Sources:
a: 1998 World Development Indicators, World Bank
b: State of the World's Children, 1998, UNICEF

Since 1994 Minisanté has conducted a series of health sector assessments which have indicated a substantial health burden and excessive mortality due to preventable and treatable illnesses. Major causes of mortality are malaria, diarrhea and acute respiratory infections. HIV/AIDS is identified as a growing epidemic and priority health and development problem with infection rates significantly higher than the already high pre-war prevalence rates.

Rwanda's capacity to plan, manage and implement basic health services has been severely damaged by the genocide. Most health facilities have been rehabilitated. However, the quantity and quality of health manpower remain a critical problem and basic accounting and administrative systems are weak.

2.1 The Government's Health Care Strategies and Reform Agenda

In the health sector, the GOR has begun the process of planning for improvements in health as evidenced in Minisanté annual health-planning document, "Ministère de Santé, Plan d'Action (PDA): 1997-98." The PDA identifies ten strategic orientations:

- Primary health care
- Community participation, both financially and in decision making
- Decentralization
- Development of human resources
- Development of the pharmaceutical sector
- Health policy research
- Inter-sectoral collaboration
- Strengthening of the HMIS
- Institutional strengthening
- Rehabilitation of health care infrastructure

Minisanté has also identified five global priority areas for the different units of Minisanté:

- Implementation of the health districts based on the WHO model
- Improvement in the capacity of Minisanté to plan and manage
- Development of human resources
- Implementation of a legal framework covering all current and planned activities in the health sector
- Rehabilitation of health infrastructure

Additionally, Minisanté has established specific priorities for each of the different units of Minisanté. For example, the priorities for the Primary Health Care Unit are to:

- Improve the quality of health services
- Ensure community participation and implementation of mechanisms to promote community solidarity in health care such as pre-payment and mutual health associations ("mutuelles de santé")
- Health care financing
- Improve the community health worker program
- Coordinate Minisanté IEC activities

As illustrated above Minisanté recognizes that it must begin to systematically rebuild its overall capacity by focusing on human resources development, strengthening priority support systems for primary health care such as administrative and financial accounting and IEC, and developing key national policies and strategies for health care financing. The Ministry has initiated a process of decentralization with emphasis on development of the health district and an integrated approach to services.

2.2 USAID's Support for Health Reforms in Rwanda

USAID assistance to Rwanda falls under an Interim Support Program designed to bridge the gap between disaster relief and a full return to development assistance. Under this program, USAID/Rwanda has identified a series of strategic objectives (SOs). In the health sector the relevant SO draws from Minisanté strategic plan and is defined as follows:

SO2: Increased use of health services and changed behaviors relative to STI/HIV, maternal and child health by building service capacity in target areas.

A series of intermediate results (IRs) define what USAID aims to accomplish under this SO. For PHR, the relevant intermediate result and associated activities are:

IR3: Enhanced sustainability of PHC services through improved financial accountability and improved health care financing

Activity IR3.1: Independent evaluation of Minisanté financial management and contracting capabilities (carried out in 1997).

Activity IR3.2: Aims to assist Minisanté to develop and pilot sound health care cost recovery systems that will ensure Minisanté meets recurrent costs within the national health care system.

The expectation of USAID is that Activity IR3.2 will be initiated and tested during the current Interim Support Program.

2.3 The Role of Other Donors in Supporting Health Reforms

A large number of multi-national and bilateral donor agencies are providing technical and financial assistance to the government in a wide range of areas. A number, including the U.S., Belgium, Canada and the Netherlands, have contributed to paying Rwanda's arrears to the international lending institutions. Other donors, particularly those which either do not have a presence in Rwanda or have limited capacity for project implementation, pass funds to a UNDP Trust Fund for activity implementation. Donors are beginning development activities in a variety of sectors, the majority focusing on democratization and justice issues. Numerous non-governmental organizations (NGOs) are also active, the majority of which are transitioning into development activities after initially coming to Rwanda to implement emergency interventions.

The structural deficiencies of the Rwandan health system are perhaps most apparent in the manner in which Minisanté matches donors with districts on a one to one basis. In this way donors provide both financial and technical support to all districts. This method of delivering assistance results in varied outcomes as donors bring varying types and quantities of resources to bear upon district activities. Furthermore, some districts remain unsupported by outside donors which results in even larger resource variations.

At present there are no donors explicitly focusing on health financing issues, though a number are undertaking activities that effect overall health system financing. The World Bank's Projet Santé et Population is providing financing and technical assistance for the establishment of the Central d'Achats des Médicaments du Rwanda (CAMERWA) which is expected to become the foundation of the GOR's cost recovery system when it becomes operational. It has also funded Health Research for Action (HERA), a Belgian consulting firm, to conduct a study of health facility costs, and quality and client attitudes. It may be that the World Bank is laying the groundwork for a future health sector project that will have a component devoted to health financing, but this is uncertain.

Médecins San Frontières/Belgique (MSF/B) financed the two-week consultancy of a health economist to the health district of Kabutare to assist the district to set prices for health services and drugs. His work was largely conceptual as he did not have time to conduct a study on the population's ability to pay for health care. Nonetheless, his work helped the district health team arrive at a conceptually sound (though empirically untested) pricing structure.

The Swiss Cooperation has earmarked $2,000,000 over the next three years for health development work, some of which may be spent on health financing issues, but no definite plans have been made. The European Union (EU) project has set aside funds for limited health financing short-term technical assistance in the years 1999-2002. No other evidence of interest in health financing was discovered by the PHR team during its initial assessment visit though many contacts expressed a strong interest in obtaining help on health financing issues.

PHR's proposed work, as outlined in this CAP, will use the information gained from other donor activities as much as possible, and will complement, as opposed to duplicate, what has already been done. PHR will also seek to collaborate with other donors for specific activities as possible.

3. Needs Assessment

During the initial PHR team visit the team held meetings with various Minisanté officials, multilateral and bilateral project personnel and NGO staff members to assess the need for health financing technical assistance and to determine what activities PHR could best initiate in Rwanda. The team also visited the health district of Kabutare to meet the district medical officer and traveled to the University of Butare to meet with the Coordinating Committee of the School of Medicine and the Assistant Dean of the School of Economics, Sociology and Business. These meetings clarified a number of issues related to health financing and health reform which are discussed here in detail.

However, in addition to these specific issues, more general issues emerged. The issues facing the Rwandan public health system can be seen as falling into three categories: short-term or immediate needs; medium-term needs; and, long-term needs, as follow:

The most important short-term needs: to establish a pricing structure for health services and essential drugs. This involves assessing the capacity and willingness of the population to pay for health services.

The most important medium term needs: to raise the overall percentage of costs of the health system borne by clients as the extra revenue is critical to the system's ability to respond to the loss of resources that will occur when NGOs start disassociating from health districts.

A related medium to long-term need: to begin laying the foundation for a comprehensive heath care financing strategy that includes a full range of health care financing options in addition to fee for service. This entails determining the methods of health care financing that are most likely to succeed and then pilot testing them to refine appropriate Rwanda-specific models.

The most important long-term need: to bolster the Rwandan health system's ability to plan, execute, monitor, and evaluate health reform activities, particularly as they relate to financing issues.

The following sections examine in greater detail the most pertinent issues that the PHR team uncovered during its initial assessment visit.

3.1 Cost Recovery and Exemption Mechanisms

Prior to the war, the GOR had instituted a policy of cost recovery or cost sharing through user fees at health centers. In 1992 this movement toward cost recovery was accelerated by the Acceleration des Soins de Santé Primaire (ASSP) program, supported by the UNICEF Bamako Initiative and the French Cooperation. In 1994, due to the social and economic disruptions caused by the civil war and the need to respond to the tremendous human suffering inflicted by the genocide, the policy of payment for service was suspended and most public health facilities as well as NGO organizations provided free health care. The cost sharing policy was re-instituted in 1995, although it is difficult to ascertain precisely how many health centers are complying with the policy. In addition, in 1995 a list of suggested maximum prices for health services was circulated to all health centers and hospitals. Each district is free to set prices for services offered, the list only gives suggested maximum prices (and it should be noted that only one district/NGO was even aware of the list of

suggested prices, so its impact has been negligible). It appears that the policy is based on fee for service (per treatment episode) with the price paid designed to cover the consultation and medication. The policy contains several logical elements designed to strengthen the PHC strategy, most notably a higher price for a curative consultation at a secondary hospital without reference. Generally, drugs and other consumables are provided to the district free of charge from a combination of the Government of Rwanda (through OPHAR) and NGO and donor organizations.

It should be noted that while evidence exists that a nationwide policy on cost sharing was instituted, compliance with the policy appears to be variable. In part, this is by design as the original policy specifically allows each district to set prices for services in relationship to the ability of the population to pay. According to both the World Health Organization (WHO) and a representative from the International Rescue Committee (IRC), when the policy was enacted, utilization initially fell significantly though later rebounded.

With WHO support, five districts have experimented with a slightly different approach based on the Bamako Initiative. In these districts, a small fee for the consultation is charged but drugs are purchased separately by patients. This approach is being followed in other districts as well but with varying degrees of subsidy for patient drug purchases.

The cost sharing policy is very likely to undergo significant change in the next several months as a de facto Bamako approach is instituted nationwide. With support from the World Bank, a new central pharmaceutical purchasing authority, CAMERWA (Central d'Achats des Medicaments Essentiels du Rwanda) was created and designed to be an autonomous self-sustaining entity. In May 1999, a new policy which affects drug supplies to the health districts was instituted. Under this policy, CAMERWA will sell drugs to each district, adding a small margin to the price of the drugs it procures to cover its operating costs. In turn, the district pharmaceutical store will do the same and markup the price of drugs purchased by the health centers in the district by an amount designed to cover operating costs of the district pharmacy. The result will be that health centers will now be forced to purchase drugs that they generally get for free under the current system. In order to maintain an adequate supply of drugs, it can be expected that most districts will implement a pricing system along the lines of the Bamako Initiative -- fee for consultation and full or nearly full cost recovery prices for drugs. In the short-term the impact of this change will be buffered in some districts by NGOs subsidizing the district's drug purchases from CAMERWA. The level of subsidization that can be expected is unclear.

Exemption from fees is possible but the mechanism for exempting clients appears to be variable. In some situations, a letter from the local commune leader (Bourgemeister) is required. In others, the district health committee ("comité de santé du district") is responsible for determining indigent status. In some districts, exemption is based on civil status, with widows, orphans and prisoners being the primary indigent categories. In other districts, returnees and/or internally displaced persons are accorded indigent status. In others, exemptions are granted on a case by case basis. Given that the genocide and war created many widows, orphans and prisoners, and that the ensuing migrations produced a huge influx of returnees and internally displaced persons, the potential number of indigents eligible for free health care has been reported to be as high as 50 percent of the population depending on adherence to the various exemption criteria. Anecdotal evidence suggests that apart from prisoners, indigent status may not be accorded as much as might be thought given the aforementioned criteria. Apparently, the disruption and economic shock created by the war and genocide has had the effect of reducing the perceived differences in economic status between those who are responsible for determining indigent status and those who are seeking it. As a result, granting of indigent status is not as regular as one might expect.

3.2 Alternative Health Care Financing Strategies

Although a national cost recovery policy was developed and implemented before the war, Rwanda appears to have little or no experience with other models for financing health care. Like many countries where the majority of the population depends on agriculture, there is reason to believe that pre-payment mechanisms have the potential to improve access to health services (by smoothing household expenditures on health) and generate additional resources for the health sector. With sufficient incentive present in the form of real fees for hospital-based care, there is reason to believe that risk pooling in the form of insurance schemes have the potential to raise resources for health at reasonable cost to the population. In general, no comprehensive health care financing policy exists that spells out how Rwanda wants to use the various components for financing health care (fee for service, pre-payment, insurance, etc.) to construct a balanced health financing system that meets health and social objectives.

Prior to the war a study conducted to assess the potential of pre-payment schemes found evidence supporting the use of pre-payment. Since then, TROCAIRE, an Irish Catholic relief agency, conducted a small study that asked respondents about their preferences for financing health care. The study compared fee for service (the current model) with an annual one-time payment (pre-payment). Approximately two-thirds of the respondents preferred the pre-payment option. TROCAIRE and MSF/B are currently considering attempting to implement a pre-payment scheme in the districts where they are working.

In Rwanda, as in nearly all health systems in Africa, there are relatively weak incentives for the health system to respond to client concerns. Managers and providers are generally paid by a central ministry (Ministry of Public Service) regardless of performance. Under the Bamako Initiative, health committees were established to ensure community participation and involvement in order to provide an incentive for the health system to respond to community needs. However, there is relatively little, if any, evidence in Africa to support this claim.

Decentralization of authority over health centers to local authorities is another approach that is in the early stages of being tested in many African countries. The authority can be devolved to local branches of Minisanté (deconcentration) or to local politicians outside of Minisanté (devolution) but it is still too early to provide a definitive assessment of the impact of either form of decentralization.

Experience in more advanced health systems has consistently shown that the manner in which providers are paid can have a substantial impact on provider and health system performance. In particular, linking provider payment to performance creates strong financial incentives for providers to meet population needs. For example, providers might be paid based on how well they perform in meeting a series of defined health goals such as immunization rates, percentage of deliveries preceded by at least two pre-natal visits, etc. Using performance based provider payment mechanisms has been shown to be a powerful tool to affect performance on various desired health outcomes.

Each of these ideas should be carefully explored in the Rwandan context to see if their theoretical merit holds in practice. Rwanda has taken steps since the 1994 war to decentralize authority by installing the WHO District Model. The Bamako Initiative was well underway before the war. The creation of new districts offers at least the possibility of trying new and innovative financing schemes.

3.3 Human Resources

Human resources in Rwanda's health sector are in extremely short supply. Many health workers fled or were killed during the genocide and ensuing war. A small number of new health workers are available as a result of the influx of returnees, but they need to familiarize themselves with the Rwandan health system. Many health centers operate with skeleton staffs where, for lack of an alternative, lower-level persons often occupy positions beyond their qualification. Minisanté operates with a handful of people at the central level, all working beyond what might be considered a sustainable level. Expatriates currently play a large role in the delivery of health services. For example, in one district alone, MSF/B supports the health system with five expatriate staff. Similar situations prevail in other districts as well.

The influx of disaster relief organizations certainly filled a void in terms of health care personnel but by their actions and presence, a series of other consequences have ensued. In order to attract and motivate health care personnel, the use of salary supplements ("primes") is commonplace in districts where relief and donor agencies are active. These supplements are significant, ranging from two-thirds to almost 100% of normal Minisanté salary on a monthly basis. In addition, some health care personnel, notably doctors, are paid another prime for working at the hospital or health center during the night ("médecin de garde"). Districts that receive no outside support provide little or no extra salary supplements.

The use of "primes" is understandable given the need to respond to the crisis situation. However, with the transition to a development mode of technical assistance and management, the ability of Minisanté to provide the salary supplements to which workers have become accustomed is in question. Moreover, anecdotal evidence suggests that newly trained health workers are taking up service in districts that benefit from support from a relief or donor agency (thus ensuring access to primes), adversely affecting the allocation of scarce health human resources.

The Government is implementing ambitious training plans to improve the qualifications of available staff and increase the number of qualified staff in an effort to meet the demands for personnel. Needless to say, this is a medium to long-term strategy but one that cannot be avoided. The Medical School at the Université National de Rwanda (UNR) in Butare is training new doctors for the Rwanda health system but the process is slow. In 1994, the Medical School only graduated 16 doctors. By the year 2000, they hope to have trained a cumulative total of 92 doctors since restarting school after the war in 1994. Other training institutes (such as Kigali Medical Center) are working hard to add to the small stock of available nurses and medical assistants.

While the Rwandan health system faces a number of issues over the next few years that require health financing and health economics expertise they currently do not have such expertise available to them. At one point, Minisanté tried to recruit a health economist but was unable to hire a single good candidate. The Department of Economics at UNR has economists who have some limited experience in health but no true health economists. Without a concerted effort to increase the capacity of Rwandans to carry out HCF and HSR, there can be little hope of any long-term impact from PHR assistance.

3.4 Institutional Fragility

In many ways the Rwandan health system has recovered extremely well from the losses suffered during the war and genocide, including the lack of human resources which puts at risk its continued development. Nonetheless, one is still struck that the health system is in flux and that the current

model is not particularly stable. The next three to five years will be crucial in its development into a mature, stable system.

From the point of view of the health system, too little attention has been paid to organizational and financial questions because so much day to day effort is needed to make the delivery of services work. For instance, personnel needs are established, plans are made to train doctors and nurses, and schools are rehabilitated or established, but no thought is given as to how the system will manage to pay these personnel given that the government is currently unable to pay its present (lower-qualified) personnel without the help of donors and NGOs.

It is difficult to see the forest when one is constantly dodging falling trees. But without long-term planning that involves an organizational/financial perspective as well as a public health/epidemiological perspective Minisanté risks dodging trees for the foreseeable future.

3.5 Health Policy and Service Delivery Research

In most countries, the ability to analyze and improve health system performance and to test new models of health system organization is present in either a Health Policy Unit or an Operations Research Unit or some combination of the two. In Rwanda, the capacity of Minisanté to undertake health policy and service delivery research is severely limited. Ordinarily, such functions might be carried out in one of two different units, the Direction de Planification et Formation (DPF) or the Division de Statistique, Recherche et Opération (DSRO). However, the DPF really has only one technical staff member at present and its primary orientation is on the management of human resources and training. For example, the DPF recently completed an assessment of health center staffing, with an analysis of currently available staff, a description of an approximate norm given the activities of the health center, and projected needs for the future. The DSRO is tasked to serve other purposes than health policy and service delivery research. This affects Minisanté's ability to make decisions based on empirical evidence and to carry out analyses in support of health sector reform. As a result, many decisions are made with no empirical support or are based on small studies of limited quality.

There are some institutions in and around Kigali that might conceivably be tapped to help respond to Minisanté needs in this area. The Office National de la Population (ONAPO) is one such institution. ONAPO was a primary USAID counterpart for population and family planning activities prior to the war. After the war, the decision was made that ONAPO would focus on population policies and research under the direction of the Ministry of Gender, Family and Social Affairs.

While it would not obviate the need to improve the ability of Minisanté to carry out other operational research and policy questions, Minisanté might consider regularly using the human resources of ONAPO for larger-scale studies that require the use of statisticians and survey specialists rather than attempting to duplicate such skills within Minisanté.

One clear need in Rwanda is for accurate information on prevalence of illness, behavior when ill, expenditures on health care, and attitudes toward alternative financing strategies. At the current time, no post-war data exist on demand for health care outside of small, limited scale studies, many of which are of indeterminate quality. This lack of information severely complicates the process of understanding demand for health care and the design of appropriate policy interventions. Several individuals are aware of this problem and are working to overcome it. ONAPO has submitted a proposal to carry out a large multi-sector household survey but the funds for the study were withdrawn by UNFPA. PHR discussed the possibility of supporting ONAPO to carry out a survey

with a health component and they are keen on the idea. However, without complimentary financing (and more than likely, a reduced sample size) PHR would be unable to fund the ONAPO study. As currently envisaged, the ONAPO study has been costed at US$400,000. This would undoubtedly be beyond the means of the PHR project. One possibility that PHR will explore is to seek co-funding from other donors such as the World Bank.

3.6 Private Sector

As before the war, the private sector in Rwanda is still quite small and restricted to the urban areas (mainly Kigali). It should be noted that, for lack of empirical evidence, this assessment is based on discussions with private practitioners. According to one private doctor in Kigali, before the war there were approximately ten private clinics in Kigali. Supervision and monitoring of the private sector was quite good and the government had a formal licensing system for the establishment of private clinics and Minisanté required private clinics to undergo inspection and verification of credentials and acceptable norms of practice. Since the war, there has been an influx of new private clinics with approximately 25 now in operation in Kigali but supervision and monitoring is virtually non-existent. Since the war, the private doctor the PHR team spoke with had not received any visit or communication from Minisanté.

Clearly, from the description above, much remains to be done to put the Rwandan health system on solid footing. The principal difficulty encountered in trying to plan appropriate technical assistance in Rwanda is not to find an area in need but rather, to identify those most in need and where PHR has a comparative advantage.

4. Proposed PHR Activities

4.1 Objectives

The overall objective of PHR activities is to work with Minisanté to improve and enhance the sustainability of primary health care services through improved financial accountability and improved health financing, as defined by the USAID/Rwanda strategic objective.

PHR will collaborate with Minisanté policy makers, program managers, local institutions, regional and district health authorities, and other donor agencies, to achieve the following CAP objectives:

1. To develop and test new models of community and health district based cost sharing with equity impacts evaluated

2. To increase human resource capacity in health care financing (HCF) and health sector reform (HSR)

3. To provide analytical support to Minisanté and USAID/Kigali during the transition period as health sector reform unfolds

For each objective, we describe below the expected results, activities to accomplish these results, and performance indicators to monitor and evaluate these activities. We also outline proposed collaborating institutions and personnel. A summary of these activities can be found in Table 1.

4.1.1 Objective 1: Develop and test new models of community and health district based cost sharing with equity impacts evaluated

One of the main features of both Minisanté and USAID strategic plans is the role accorded to the development and pilot testing of alternative health care financing schemes. This is an appropriate emphasis because, as noted above, a well balanced health financing system will contain a variety of mechanisms for financing health care, and pilot tests of alternatives to fee for service is an important first step in identifying locally suitable financing options. Moreover, pilot tests of new options will allow potential problems to be identified prior to nationwide implementation.

The first component of PHR assistance in this area is to perform a rapid assessment of alternative financing options. This will consist of a thorough review of all available data and studies on health care demand and supply and existing research on financing options. The product of this assessment will be a set of preferred HCF options to be tested. Evidence gathered during the PHR assessment visit already indicates that prepayment schemes are likely to be successful if properly and carefully implemented. What is less clear is how and by whom the prepayment scheme would be managed. Several options for running the prepayment scheme are possible. For example, in some districts, the district management team is strong and could conceivably manage the scheme. This option would make use of existing administrative and managerial expertise already present in the district. The

district health committee could then serve as the "board of directors" for the scheme, ensuring citizen input and a community orientation.

Another possible option is to separate providers and payers. For example, an existing association such as an agricultural marketing association or an emergency transport mutuelle might be approached to set up and manage a pre-payment scheme. The association would inform members and the community, collect enrollment fees, and pay providers. This is a common model for many West African mutuelles, where an existing association functions as the third party payer. These types of financing mechanisms have the advantage of making use of existing (often indigenously developed) associations. It is even conceivable that more than one mutuelle prepayment association could be established, ensuring consumers have a choice of health plans. In either case, the mutuelle would negotiate a contract with the district (although nothing would theoretically prevent them from contracting with private providers) to provide care for the enrolled members of the association. These contracts could take several forms, depending on how the association elects to reimburse providers. Among the options to be considered are: simple fee for service reimbursement, fee per episode reimbursement, reimbursement based on a fee schedule set by the association (akin to a Diagnosis Related Group or DRG approach), reimbursement based on a fee schedule negotiated between the district and the association (similar to the approach used in Canada), and possibly even capitation, i.e., reimbursement based on a fixed cost per person.

Considerable dialogue will be necessary both with the health district management teams and with the district health committees to identify possible districts, ensure all parties understand the nature of the scheme to be pilot tested, and that input from local communities is included in all phases of testing and evaluation.

A final component of proposed PHR technical assistance is to explore, and possibly conduct a pilot test of, alternative management reforms affecting the structure of health service delivery. For example, one option might be to set up the existing health district as an autonomous non-profit organization responsible solely for providing health care services to the catchment population. The autonomous district could use a variety of forms to collect payments from the members of the district from fee for service to prepayment. In turn, the health district would be free to contract with providers of its own choosing, negotiating terms of service outside of traditional civil service agreements. Providers would receive a market determined wage, which is likely to be above what they currently receive in the public health system. In return for these potentially higher wages, providers would have to accept greater responsibility for providing quality services and ensuring client satisfaction. Failure to perform could result in termination. An option such as this has the advantage of giving health districts full control over the resources they need to provide health services to their clients. It must be emphasized that this is merely an illustrative example of one possible option for restructuring health services that departs from more traditional forms of health service delivery organization. PHR is not proposing to implement this scheme, rather PHR proposes to open a dialogue with Minisanté and members of the health districts to see if there is any interest in experimenting with options for restructuring health care service delivery such as the one described above.

Result 1.1

Current health service pricing practices assessed in pilot districts.

Activities/Possible Partners:

PHR will conduct structured interviews with Minisanté field staff and political key informants. The interviews will yield both qualitative and quantitative information. The tools will be developed with the DSSP and ONAPO. The interviews will be conducted together with regional and district level Minisanté staff.

Performance Indicators:

1. Tools developed
2. Study conducted
3. Results disseminated to decision makers to help build consensus
4. Consensus on how to proceed reached and documented

Result 1.2

Reintroduction of cost recovery across Rwanda monitored and evaluated (focusing on selected health districts).

Activities/Possible Partners:

This activity follows from Result 1.1 immediately above. The initial analysis is embedded in that activity. However, it is felt that there will be a need to monitor cost-recovery initiatives across parts of Rwanda (outside of the 3 intervention districts) over the life of the project. A strong understanding of the performance of various financial indicators outside of PHR's intervention districts will allow for a better understanding of the impacts of the prepayment schemes. The monitoring of CR will be done with Minisanté partners.

Performance Indicators:

The activity will be ongoing and will vary in its level of formality. Intermediate products will include activity and field trip reports by PHR personnel. At the end of the project information from the monitoring process will be included in a final report so that Rwandan health planners can better decide on how to move forward on a larger scale introduction of the chosen financing strategies. This final report will be in the form of a policy paper and/or paper.

Result 1.3

Rapid feasibility assessment of alternatives to fee-for-service such as mutuelles, prepayment schemes for health districts or community based insurance programs conducted.

Activities/Possible Partners:

The above information will help PHR and Minisanté decide which alternatives to choose for pilot testing. The choices will be made at a series of workshops in Bethesda, Kigali and at various field sites. The workshops will arrive at decisions through the presentation of information and guided discussions hopefully leading to consensus. Partners will include USAID/Kigali, Minisanté, ONAPO, and various local government officials.

Performance Indicators:

Consensus achieved on preferred alternatives to fee-for-service and interventions chosen based on this consensus.

Result 1.4

Two alternative financing schemes designed and pilot tested.

Activities/Possible Partners:

This result represents the crux of PHR's work in Rwanda. Working very closely with both Minisanté and the local governments in the pilot districts, PHR will design and implement at least two financing schemes, most likely based on prepayment, in districts chosen in consultation with the Government of Rwanda.

The implementation of the prepayment schemes will face a dilemma. On one hand, the schemes need to be put into place by July 1999 to take advantage of the larger of the two annual harvests in Rwanda. On the other hand, no matter how carefully the schemes are designed and no matter how high the level of community participation, the initial systems will not be perfect. So the project will implement the schemes in the summer of 1999 but will continue to monitor and improve them to win user confidence based on the early results from the implementation.

This will involve careful monitoring of the interventions as they happen and an iterative design process that can incorporate the lessons learned from the initial implementation into the ongoing prepayment scheme.

Performance Indicators:

This result will be accomplished when pilot schemes are successfully implemented in at least 2 health districts. PHR will produce progress reports and a final evaluation report documenting key findings, conclusions and recommendations. The long-term impact will come from the Government of Rwanda using the results from the pilot schemes as a basis for implementing larger scale changes to their health financing system.

Result 1.5

Exemption mechanisms evaluated and changes recommended in PHR pilot districts.

Activities/Possible Partners:

This activity will be two-pronged. For the pilot districts the exemption mechanisms are inextricably linked to the pricing of the prepayment/insurance plans. As such, the mechanisms needed to deal with indigence will be discussed and implemented with all the partners discussed in the above section on pilot financing scheme development. PHR will also track issues related to exemption mechanisms in non-pilot districts. This will be done in partnership with local government leaders, Minisanté and whatever donor agencies are working in specific districts. Should the information gathered warrant it, a policy or position paper would be written for Minisanté and the government of Rwanda.

Performance Indicators:

Exemption guidelines developed and instituted in the PHR pilot districts.

4.1.2 Objective 2: Increase human resource capacity in health care financing (HCF) and health sector reform (HSR)

The nature of the reforms Minisanté and USAID would like to pilot test virtually requires the oversight and involvement of a health economist. Given the immediate need for building local expertise in health economics and to ensure a transfer of knowledge from PHR to Rwandan nationals and Minisanté, PHR proposes to hire (or have Minisanté hire) one to two Rwandans to serve as full-time staff on these activities. Training will be "on the job." Already, Minisanté has given tentative consent to hire at least one person, to be located in the PHC Unit.

To fill an immediate need for an overview of the basics of health financing and economics, in conjunction with the UNR Department of Economics and the Medical School, PHR will offer an intensive course (2 weeks) in health financing and economics for new Medical School graduates who are likely to soon find themselves in the public sector health system. In the long run, PHR will work with the UNR Department of Economics to assemble a course in Health Economics that can eventually be incorporated into the university curriculum and taught by faculty from the Department of Economics.

Result 2.1

Local capacity developed by hiring one or two local advisors to receive on-the-job training in HCF and HSR.

Activities:

PHR will identify and hire two local advisors for on the job training in HCF and HSR. Their training will be augmented by participation in some more formal coursework in HCF.

Performance Indicators:

Two advisors hired and in place, training accomplished.

Result 2.2

HCF intensive course (2-4 weeks) taught

Activities:

In conjunction with UNR Medical School and Economics Department, PHR will teach an intensive course (2-4wks) in HCF. PHR will develop a curriculum appropriate to Rwanda and teach the course in conjunction with UNR faculty. The UNR faculty will be trained in the course curriculum so that they can take over the teaching role in future years. In addition, through arrangement with the UNR, when senior level PHR staff are in country on TDY's, they will lecture at the University on various issues related to HCR and HCF.

Performance Indicators:

Course developed and taught, with documentation of number of participants and course curriculum.

Result 2.3

On-the-job training in health service delivery research during pilot tests provided to DSS staff.

Activities:

As discussed above, the lack of HCF knowledge within Minisanté is one of the larger barriers to the long-term success of this activity. As such, PHR will work diligently to include DSS staff as much as possible in the development and implementation of the financing schemes, using the practical experience as a tool to further their HCF knowledge.

Performance Indicators:

DSS and other Minisanté staff included in pilot financing scheme development and implementation (obviously, the success of this activity depends largely on the availability of DSS staff).

Result 2.4

Development and implementation of a course on health economics at the UNR.

Activities:

PHR will work with the UNR to develop and draft a course curriculum. PHR/Bethesda will then prepare the teaching materials needed to teach the course. It is likely that existing health economics curriculum materials already developed by PHR staff, some of them already in French, can be adapted for use in Rwanda. The majority of the teaching will be done by UNR Department of Economics Staff, with support from Medical School Professors, but PHR may help team teach one two-week intensive section of the course. After the course is completed, PHR will help evaluate and modify the course curriculum as needed.

Performance Indicators:

UNR holds course.

4.1.3 Objective 3: Provide analytical support to Minisanté and USAID/Kigali during the transition period as health sector reform unfolds

These activities are included to ensure PHR can respond to Minisanté requests to assist in formulating responses to emergent issues in the area of HCF. It is assumed that in the course of project activities, issues that need analysis and a technical response will present themselves. This component ensures that PHR will have the capacity to respond to this need when and if necessary.

Result 3.1

The analytical support needs will be determined as the project develops. The situation on the ground in Rwanda is in constant flux, and it is not possible to assess well in advance what needs will arise over the course of a 21 month project.

Performance Indicators:

Analytical support provided in response to specific requests from Minisanté and USAID/Kigali as mutually agreed and within time and budget constraints related to other objectives.

4.2 Long Term Resident Advisor

To carry out the proposed health financing work plan for Rwanda successfully will necessitate a serious commitment from both Minisanté and PHR. PHR proposes the installment of a long-term advisor to Minisanté SSP for the following reasons:

Since it has been established that Rwanda lacks trained personnel with health economics and/or health financing backgrounds, PHR must bear much of the responsibility for the technical support of proposed activities. This could be done either through short-term or long-term technical assistance approaches. For the implementation of this CAP, PHR proposes a combination of the two.

A cost comparison of the two approaches demonstrated that they were of roughly the same cost (because of the large amount of short-term technical assistance that would be needed but the long-term approach would yield approximately 100 more person days of effort for the same cost.

The continuous onsite presence of a long-term advisor in Minisanté SSP offices would also be more likely to lead to Minisanté institutionalizing health sector financing and reform into its day to day activities compared to the intermittent presence of short-term technical assistance, and on-the-job training to Rwandan staff would be provided.

Activities are likely to run more smoothly, particularly as related to logistical and administrative issues, with the presence of a long-term advisor. The advisor, in coordination with an Minisanté agent in the SSP division, would be able to closely monitor the pilot activities and respond quickly as needs arise. PHR's prior experience suggests that this capacity to respond quickly and directly significantly contributes to success of such pilot projects.

The Director of PHC Division at Minisanté has expressed a willingness to assign an Minisanté agent to work in tandem with the PHR long-term advisor, the two would share the same office in the SSP division. Through daily contact and informal mentoring Minisanté agent would acquire the capability over the two years of the project to continue managing health financing and health reform activities after the departure of the advisor. Thus, PHR would be contributing to the sustainability of health reform efforts.

For all of these reasons PHR strongly suggests that a long-term advisor be installed in the SSP offices for the two-year duration of activities.

5. Training Plan

Training is an integral part of the activities under all of the objectives of this CAP and will be critical to achieving capacity building results. Training will occur through:

- workshops to introduce activities, identify priorities, and obtain input/participation from local counterparts
- formal training for selected Rwandans for in-country and/or overseas courses in health care economics and financing
- on-the-job training through direct one-on-one work with counterparts e.g. hired local advisors at SSP working with PHR long term advisor, and those assisting with research and pilot studies
- workshops and other meetings to disseminate results and lessons learned

Training will be preceded by needs assessments, consisting of a combination of interviews, focus groups, formal surveys, and other methods depending upon the activity. All training needs assessments and related training will be done with substantial involvement of the PHR Training Coordinator who will prepare reports on the results of formal and informal training activities.

6. Information Dissemination Plan

The survey and assessment instruments, training materials, pilot models, results and lessons learned from PHR Rwanda activities will be disseminated widely within Rwanda, the region, and globally, in an effort to promote and expand health sector reform.

- specific training and dissemination activities and products included in the CAP:
- policy presentation on evaluation of exemption mechanisms (presentation)
- community and health district based cost sharing model and results of pilot tests (technical reports)
- alternative financing schemes models and results of pilot tests (technical reports)
- alternative models of organizing and delivering health services tool and results of pilot tests (technical reports)
- report on on-the-job training (report)
- health economics curriculum (technical report)
- technical reports produced as a result of the work performed under the analytical needs section of the workplan

Dissemination mechanisms used by PHR will include paper and electronic dissemination of written products; workshops to inform counterparts of plans and results and to seek their input; meetings with key national, regional, and community level leaders to inform them of PHR initiatives and to seek their guidance and support; and a proactive effort to coordinate with other international donor programs and USAID cooperating agencies operating in Rwanda.

7. Evaluation Plan

PHR's performance will be measured against the objectives, performance indicators, and target dates set out in this CAP and shown in Table 1. The district financing pilot schemes will be implemented in three pilot districts and their results will be evaluated in comparison with data from two control districts. A more detailed evaluation plan will be developed as the work progresses.

PHR management will internally review the progress of its Rwanda activities each quarter and the results of these reviews will be included in PHR quarterly reports, reviews and performance assessments. PHR will also review the progress of our activities with Minisanté officials and USAID representatives when PHR staff are in country. Recommendations on changes in the performance indicators or timing resulting from these reviews will be made in collaboration with Minisanté officials, USAID, and PHR management.

8. Management and Monitoring Plan

In-country management and provision of technical assistance for PHR activities will be provided by the PHR Resident Advisor who will be responsible for implementation of all CAP activities. This individual will work closely with Rwandan counterparts in Minisanté and other institutions to identify, plan, and implement technical assistance activities, and provide on-the-job training to local counterparts in health economics, policy analysis and formulation, as well as other areas. The Advisor will serve as PHR's point person for all project activities, coordinating closely with the USAID, the Rwandan Minisanté, and the management team of PHR.

US-based staff will provide both technical and managerial support and oversight to the PHR Resident Advisor. A Program Officer will be responsible for the day-to-day managing from the U.S. of activities, including identifying and fielding appropriate staff and consultants for field visits; interacting with USAID/Rwanda, USAID/Washington, and the Resident Advisor; ensuring that all reports and other products are submitted on time; and providing overall managerial and administrative support for field activities. The Program Officer will be supported by PHR administrative and accounting personnel who will assist in all administrative, logistical, and travel needs and play a lead role in fielding and supporting the Resident Advisor.

Other specialized technical personnel will not only conduct short-term assignments, but also contribute to the items listed in the last sentence, e.g., technical guidance, review of documents, etc. These may include PHR Technical Officers, Training Coordinator, Consultants, Research Analysts and Assistants. The PHR Technical Director and Regional Coordinator will provide overall technical guidance in the planning, implementation, and monitoring of activities, as needed and review all technical reports and other products.

9. Budget and Estimated Level of Effort

Table 3 shows the estimated costs and level of effort for proposed PHR activities for years 1 and 2. These LOE and budget estimates include long-term resident advisor costs, home-based direct support, as well as work performed in the field. PHR's budget estimate for its proposed Year 1 and 2 activities comes to approximately $1.77 million.

In order to be responsive to GOR and USAID/Rwanda interests, activities as specified may be adjusted. The schedule for activities is included in Table 3.

Table 3: Level of Effort and Budget for Proposed PHR Activities for FY1999 and FY2000

Category	*LOE (days)*	*Budget*
Long-term Advisor, FSNs, and Site Office	2,043	$713,552
Home Office & Technical Backstop	584	$269,390
Development and Implementation of Pilots for Cost-Sharing	139	$264,392
NHA	0	$85,452
Formal training	65	$122,365
Analytical Support	252	$320,916
Total	3537	$1,776,069